Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2567
www.caldocinfo.ca.gov

NOTIFICATION OF NAME CHANGE

Please indicate license type below:

Physician & Surgeon ☐ Midwife ☐ Spectacle Lens Dispenser/Contact Lens Dispenser ☐

IMPORTANT: The first line of the declaration MUST indicate the name you used prior to your name change.

DECLARATION

I, _____ _____ _____ (name prior to change)
(First) (Middle) (Last)

hereby certify that I was **originally issued and currently hold** license/registration

number(s) _____ to practice in the State of California.

I further certify I have assumed the name of:

_____ _____ _____
(First) (Middle) (Last)

based on one of the following:

Court Order ○ Marriage ○ Naturalization ○ Dissolution of Marriage ○

Other (Specify) ○ _____

This is my new adopted name for all purposes, and this name change has not been made for fraudulent purposes.

You **MUST** submit a certified copy of the following documents where applicable. If a photocopy of the certified copy is submitted, it must be notarized. Submit this form to the Medical Board of California at the address shown above:

☐ Marriage Certificate ☐ Final Dissolution Decree ☐ Copy of Court Order

This notification does not generate a duplicate certificate. Please contact the Medical Board for an application for a duplicate license, if you wish a certificate reflecting this name change.

BOTH PAGES OF THIS FORM MUST BE COMPLETED.

PHOTOGRAPH

PHOTO AREA	**PHOTO DECLARATION**
PASTE A 2 1/2 X 3 1/2 INCH BLACK AND WHITE OR COLOR PHOTO OF PROFESSIONAL QUALITY HERE. **PHOTO MUST BE OF YOUR HEAD & SHOULDER AREAS ONLY AND MUST HAVE BEEN TAKEN WITHIN THE LAST 12 MONTHS.** **PROOF/NEGATIVE/ DIGITAL OR POLAROID TYPE PHOTOS ARE NOT ACCEPTABLE.**	I hereby declare under penalty of perjury under the laws of the State of California that the photo of me attached hereto, was taken on or about _____. Applicant's Signature: _____

TELEPHONE NUMBER

CURRENT MAILING ADDRESS

Address:

City: State: Zip:

☐ **Check here if this is a change of address** so that your record can be updated. If this is a post office box, you must list a confidential street address.

NOTICE: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information provided will be used to identify the licensee and to verify the licensee's identification under Section 2081of the Business and Professions Code. Applicants have the right to review their application subject to the provisions of the Information Practices Act. The Licensing Program Chief is the custodian of records. Information in this application may be transferred to other governmental and law enforcement agencies.

AFFIDAVIT

I certify under penalty of perjury under the laws of the State of California that the information provided on this form, including supporting documentation and photograph of me, is true and correct and that I am licensed/registered to practice in the State of California.

_____ Date

Applicant's Signature

NOTARY

This individual, _____, has appeared before me, signed in my presence and is identified as the above individual. Subscribed and sworn to before me this _____ day of _____,_____.

_____ _____

Notary Public's Signature Telephone Number

Address_____

My commission expires _____. SEAL